Immunize Utah

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An Ounce of Prevention: Communicating the Benefits and Risks of Vaccines to Parents

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Truths About Vaccines

Not long ago, the public embraced vaccination as nothing short of a medical miracle. Children lined up outside clinics with smiles and sleeves rolled up, eager to receive a lollipop, a Polio Pioneer button and a shot. None of them knew if the shot contained the vaccine or placebo, but they considered themselves lucky for the chance to participate in history. The polio vaccine, along with other vaccines before and after it, constitutes one of the most important public health initiatives ever invented.

Fear of disease vs. fear of vaccines

Today, physicians find themselves challenged by parents to explain why vaccines are necessary, and they are called to defend the safety record of vaccines in the face of proliferating misinformation and anti-vaccine rhetoric. On September 18, 2002, an interactive symposium was held in Chicago entitled "An Ounce of Prevention: Communicating the Benefits and Risks of Vaccines to Parents." Sixty-five pediatricians from a variety of practice settings were convened with a distinguished faculty to develop a framework for communication with parents that informs, answers questions, empowers parents with scientific facts and preserves the successes of immunization programs.

Inside this Issue

One could ask the simple question: "What has changed since the days of Albert Sabin, MD, and Jonas Salk, MD?" The answer is that diseases have disappeared and fear of disease has been replaced by fear of vaccines. It is necessary to continue to reevaluate the risk/benefit formula regarding vaccines. For example, the risk of vaccine-associated paralytic polio (VAPP) caused by oral polio vaccine (OPV), estimated to occur once for every 2.4 million doses distributed, was acceptable at a time when 20,000 devastating cases of natural polio occurred each year in the United States.

Table 1: Misconceptions About Vaccines

1. Diseases disappeared before vaccines were introduced
2. Most people who get sick have been vaccinated
3. Many vaccines cause serious adverse events
4. Vaccines cause many illnesses and deaths
5. Vaccine-preventable diseases are rare
6. Multiple vaccinations overload the immune system

However, with no cases of natural polio in the country since 1979 and no cases in the Western Hemisphere since 1991, the risk of five or ten cases of VAPP each year outweighed the benefits of OPV. This is what prompted the switch to the inactivated polio vaccine (IPV) in 2000.

The history of the polio vaccine illustrates that, in policy-making, risks and benefits are carefully weighed.

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Utah Adult Immunization Coalition
Ethnic Minorities Survey Results 2006

Nasrin Zandkarimi, M.Ed
Utah Immunization Program

The Utah Adult Immunization Coalition (UAIC) formed a Target Population subcommittee with a goal to increase immunization rates and awareness among ethnic populations in Utah. This subcommittee developed two surveys—one for providers and one for the ethnic minority communities. The Provider Survey was designed to evaluate barriers for providers in administering immunization services to ethnic populations in their clinics. The Community Survey was designed to evaluate barriers for minority communities in accessing immunizations.

The following survey results are for the two separately conducted surveys. The Provider Survey was administered in clinics that are part of the following programs: community health centers which are members of the Association for Utah Community Health (AUCH), homeless health care programs, minority and migrant outreach programs, local health departments, Seraphine Clinic, Maliheh Free Clinic, Utah Partners for Health, University of Utah Partnership, and the Tribal and Indian Health Services (IHS) health programs.

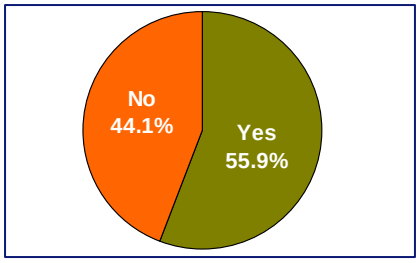

Chart 1: Providers who believe their clinics have barriers to immunizing minority groups

The Community Survey was a convenience sample including, most importantly, ethnic minority groups. It consisted of surveys given by Holy Cross Ministries, Comunidades Unidas, and the Indian Health Advisory Board.

Results of the Provider Survey are as follows:

Approximately 50% of providers who responded to the survey said they believe their clinic/agency/organization has barriers to immunizing minority populations (Chart 1). Providers indicated the main barriers facing minority populations include language barriers, transportation to and from clinics, and insurance eligibility issues. About 79% said they offer translated information to help address those barriers. Another three-quarters (73.7%) of these providers said bilingual staff are an option. A little more than one-half (52.6%) said they display culturally and linguistically appropriate posters and flyers in their waiting rooms; around one-third (36.8%) said they use periodic cultural sensitivity training for staff. About 45% of the providers surveyed said that they have minority clients who refuse immunizations (Chart 2). Some of the reasons for this refusal include financial reasons; a lack of information on immunizations and "other" personal reasons by the client.

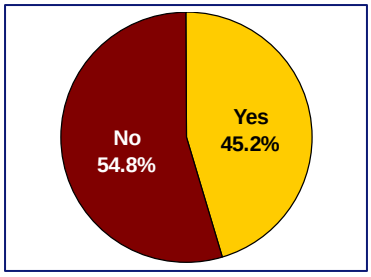

Chart 2: Providers who have clients that refuse immunizations

Providers indicated several different ways to deliver immunization information. Over half (58.8%) of providers said the message about immunizations is delivered through face to face contact. Just under half (44.1%) said they get the message out through flyers; posters (41.2%), or newspapers (41.2%). Close to one-third (29.4%) said they send the message through radio and some utilize "other" means (26.5%) including schools, churches, clinics, or Care-A-Van mobile immunization clinic. About one-quarter (23.5%) work through health events and some (17.6%) send out the message by telephone.

When questioned about simultaneous immunization, over three-quarters (78.1%) of providers said they require that all immunizations be given to bring children up-to-date at the same visit. Just under one-quarter (21.9%) said that they do not require that all immunizations be given at the same visit. These providers also said that they make recommendations and let the parents decide. Simultaneous immunization may also depend on the cost of all necessary immunizations at the time.

Results of the Community Survey are as follows:

The largest percentage (78.2%) of those who responded indicated they were Hispanic (Chart 3).

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HPV and Rotavirus Vaccine Recommendations

ACIP Provisional Recommendations for Quadrivalent HPV Vaccine

- Routine vaccination with three doses of quadrivalent HPV vaccine is recommended for females 11–12 years of age. The vaccination series can be started in females as young as 9 years of age.
- Catch-up vaccination is recommended for females 13–26 years of age who have not been vaccinated previously or who have not completed the full vaccine series. Ideally, vaccine should be administered before potential exposure to HPV through sexual contact.
- Quadrivalent HPV vaccine is administered in a three-dose schedule. The second and third doses should be administered 2 and 6 months after the first dose.
- Quadrivalent HPV vaccine can be administered at the same visit when other age-appropriate vaccines are provided, such as Tdap, Td, and MCV4.

Special Situations:

- Quadrivalent HPV vaccine can be given to females who have an equivocal or abnormal Pap test, a positive Hybrid Capture II high-risk test, or genital warts.
- Vaccine recipients should be advised that data from clinical trials do not indicate the vaccine will have any therapeutic effect on existing Pap test abnormalities, HPV infection, or genital warts. Vaccination of these females would provide protection against infection with vaccine HPV types not already acquired.
- Lactating women can receive quadrivalent HPV vaccine not already acquired.

Females who are immunocompromised either from disease or medication can receive quadrivalent HPV vaccine. However, the immune response to vaccination and vaccine effectiveness might be less than in females who are immunocompetent.

Contraindications to use of vaccine:

- Quadrivalent HPV vaccine is contraindicated for people with a history of immediate hypersensitivity to yeast or to any vaccine component.

Precautions:

- Quadrivalent HPV vaccine can be administered to females with minor acute illnesses (e.g., diarrhea or mild upper respiratory tract infections, with or without fever).
- Vaccination of people with moderate or severe acute illnesses should be deferred until after the illness improves.

CDC Publishes Recommendations For Prevention of Rotavirus Gastroenteritis

In February 2006, a live, oral, human-bovine reassortant rotavirus vaccine (RotaTeq®) was licensed for use among U.S. infants.

The ACIP recommends routine vaccination of U.S. infants with three doses of this rotavirus vaccine administered orally at ages 2, 4, and 6 months. The first dose should be administered between ages 6-12 weeks. Subsequent doses should be administered at 4-10 week intervals, and all three doses should be administered by age 32 weeks.

Rotavirus vaccine can be administered with other childhood vaccines. Rotavirus vaccine is contraindicated for infants with a serious allergic reaction to any vaccine component or to a previous dose of vaccine. Log on to:

http://www.cdc.gov/nip/recs/provisional_recs/default.htm to read all ACIP provisional recommendations.

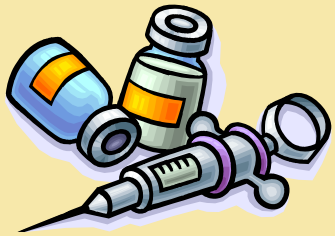
Vaccine Management Tips

Reminder: Flu season is right around the corner. Remember to follow best practice for ensuring safe and effective vaccine administration.

General Recommendation

The National Immunization Program (NIP) of the Centers of Disease Control and Prevention and the Utah Immunization Program strongly recommend that providers draw vaccine only at the time of administration to ensure the cold chain is maintained. Prefilling syringes is strongly discouraged due to the following possible serious consequences:

- Administration errors
- Inappropriate storage conditions leading to vaccine wastage
- Bacterial contamination and growth
- Reduction in vaccine potency
- Quality control and patient safety problems *(If you do not draw up the vaccine yourself, you cannot be sure of the composition and sterility of the dose you are administering.)*



Prefilling Syringes for Influenza Clinics

Although predrawing vaccine is generally discouraged, **a limited amount of vaccine may be predrawn in a mass immunization setting if** the following procedures are followed:

- Only one vaccine type is administered at the clinic.
- Vaccine should **NOT** be drawn up in advance of arriving at the clinic site.
- Vaccine should remain in the original manufacturer packaging during transport.
- Inactivated influenza vaccine must be packaged and transported appropriately within NIP's guidelines; monitored and maintained at 35˚-46˚F (2˚-8˚C).
- Each healthcare worker should draw up a small quantity of vaccine to meet the initial needs of the clinic -- no more than 1 vial or 10 doses.
- To conform to good administration practices, each healthcare worker should administer only the vaccine he or she drew up.
- Patient flow should be monitored to avoid drawing up unnecessary doses.
- At the end of the clinic day, any remaining vaccine in syringes should be discarded. Vaccine that has been drawn up and not administered may **NOT** be used on subsequent days.

Proper Storage & Handling Practices

Keeping VARIVAX and ProQuad Viable

VARIVAX®

ProQuad®

VARIVAX and ProQuad are both varicella-containing vaccines with most of the same storage and handling requirements applicable to both vaccine types.

Carefully following VARIVAX and ProQuad storage and handling requirements will ensure that there is no loss of vaccine potency.

- Both vaccines are received frozen; shipped on dry ice.
- Both vaccines must be stored continuously in a chest or frost-free freezer that has a separate sealed door at 5˚F (-15˚C) or colder. (Dorm fridges are NOT acceptable storage.)
- Protect from light at all times since such exposure may inactivate the vaccine viruses.
- Vaccines should be administered immediately after reconstitution.
- Discard reconstituted vaccine if it is not used within 30 minutes.
- Do NOT freeze reconstituted vaccine.
- ***Prior to reconstitution, VARIVAX may be stored at refrigerator temperatures (35-46˚F / 2-8˚C) for up to 72 continuous hours. (After 72 hours, it must be discarded if not used.)***
- ***ProQuad must never be stored in the refrigerator and it must be kept frozen at all times at 5˚F (-15˚C) or colder.***

Transportation of VARIVAX or ProQuad to an off-site clinic or other location for administration is strongly discouraged.

For information regarding the stability under conditions other than those recommended, call 1-800-MERCK-90.

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Ethnic Minorities Survey

However, no distinction between race and ethnicity were made at the time the survey was developed. The survey results were predominantly from Hispanic and American Indian populations.

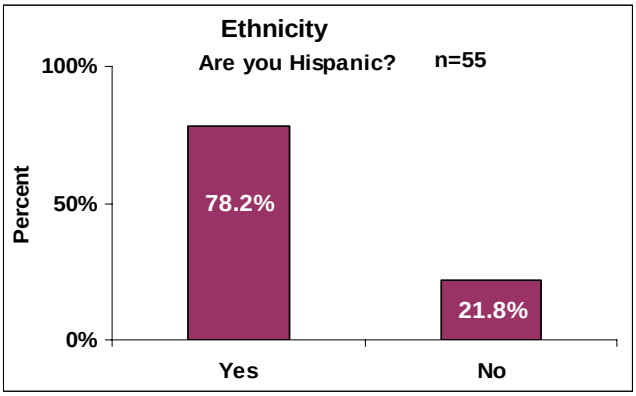

Chart 3: Race/Ethnicity

When asked if getting vaccines was an important health issue for them or their families, 85.3% of the respondents said yes. A large majority (86.6%) of those said they had never experienced difficulty in getting vaccines.

The survey indicated that ethnic communities may not always receive immunization information through mainstream media or print materials. *Only 14.5% of the communities surveyed reported that they heard about vaccinations through radio, flyers or posters;* 7.2% through newspaper; and 8.7% got information at events. About 55% indicated “other” and the majority of answers for “other” included health fairs (43.8%), doctor/clinic (25.0%), and a variety (31.2%) of additional answers. This may be significant when compared to the percentage of providers (23.5%) who utilize venues such as health fairs to promote immunizations.

Many of the communities surveyed (64%) were not familiar with the Vaccines for Children (VFC) Program. Of the communities that did know about the VFC Program, 71.4% said their children had received VFC vaccines.

A large percentage (67%) of those surveyed said that they knew there are vaccines for adults. Only 47% said they had received a flu shot within the past year.

While these two surveys are not absolute in their conclusions among all providers and ethnic groups, the results may provide some insight to reducing immunization barriers among ethnic populations and help providers better understand how to effectively serve these groups.

Temporary Strain on ADACEL Vaccine

Sanofi Pasteur is experiencing a temporary strain on ADACEL® (Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine Adsorbed) vaccine supply.

There are several factors currently impacting supply of ADACEL vaccine including strong uptake within physicians' offices and peak seasonality for booster immunization. Sanofi Pasteur is in the final phases of increasing their capacity to meet this surge in demand for ADACEL vaccine with a new pertussis production facility.

While awaiting availability of ADACEL vaccine doses from this facility, Sanofi Pasteur will be experiencing a temporary strain on ADACEL vaccine supply. As a result, it is necessary for Sanofi Pasteur to implement order limitations for a short period of time.

This is a temporary situation and providers are urged to continue immunizing with ADACEL vaccine in accordance with the Advisory Committee on Immunization Practices' provisional recommendations for Tdap use as identified in the Centers for Disease Control and Prevention's recently published Vaccine Information Sheet (VIS).

During this interim period, the use of ADACEL vaccine should be focused on adolescents 11-18 years of age and on adults 19-64 years of age who have close contact with infants (eg, parents, child care providers, health-care workers).

It is important to note that the VIS states:

- Td should be used in the event that Tdap is not available, and for anyone who:
- Has already received Tdap,
- Anyone 65 years of age and older, and
- Children 7-9 years of age.

For these patient populations, DECAVAC® (Tetanus and Diphtheria Toxoids Adsorbed For Adult Use) is available in ample supply for immediate use.

For more information on ADACEL vaccine supply and other vaccine shortages, visit
http://www.cdc.gov/nip/news/shortages

Mark Your Calendars!

2006 Events

September 24-30, 2006
Adult Immunization Awareness Week

September 27, 2006
Central Utah VFC Provider Luncheon
Frontier Village Restaurant, Richfield
12:00 - 1:30 p.m.

September 27, 2006
Utah Flu Summit
Red Lion Hotel, Salt Lake City
8:30 a.m. - 12:30 p.m.
Call 801-538-9450 for more information.

October 19, 2006
Utah Scientific Vaccine Advisory Committee
IHC University Building, Salt Lake City
Classroom 6, 8:00 a.m.
Call 801-538-9450 for more information.

November 2, 2006
Every Child By Two Immunization Coalition
Utah Department of Health, Salt Lake City
Room 101, 10:00 a.m.
Call 801-538-9450 for more information.

November 14, 2006
Southwest Utah Immunization Coalition
Southwest Utah Public Health Department
168 North 100 East, ST. George
Upstairs Conference Room, 8:00 a.m.
Call 435-986-2588 for more information.

December 12, 2006
Utah County Immunization Coalition
Utah County Health Department
151 South University Ave., Provo
2800 2nd Floor Admin. Offices, 8:00 a.m.
Call 801-851-7050 for more information.

Utah Adult Immunization Coalition meets the fourth Wednesday of each month at Health-Insight, Salt Lake City, 8:00 a.m.
Call 801-538-9450 for details.

Kudos To Providers!

The Utah Immunization Program is proud to recognize outstanding efforts in immunizing Utah's children. We are pleased to recognize the following providers for rates shown during recent immunization assessments from May through August 2006 using the Clinic Assessment Software Application (CASA).

For achieving the goal of immunizing 70% or more of two-year-olds with 4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B and 1 Varicella:

Summit Pediatrics, Park City 72%

REMINDERS!

Providers - - sign up to receive the IAC Express and get timely immunization updates, especially announcements about VISs. Sign up at http://www.immunize.org/express.

USIIS Users - - update your bookmarks and shortcuts to the new USIIS application web address at https://apps.usiis.org/webkids/. If you need help, call 801-538-9450.

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An Ounce of Prevention

However, in recent years, some parents have become convinced that vaccine policies ignore the "facts" about vaccines, many of which are actually misconceptions perpetuated on the Internet and in the lay press. Some of these misconceptions are addressed by the Centers for Disease Control and Prevention in a paper entitled "Six Common Misconceptions About Vaccination and How to Respond to Them" (Table 1).

Vaccine truths

The truths about vaccines are also worth reviewing. First, that vaccines have been an important public health achievement, has already been alluded to (Table 2). The second truth is that public concern about vaccines is pervasive. Articles in magazines, segments on television talk shows, sound bytes on the evening news, hearings on Capitol Hill and conversations at dinner parties all attest to this. The third truth, that fear of vaccines can lead directly to public harm, may not be so obvious. In the United Kingdom and other countries in the 1970s, fear that whole-cell pertussis vaccine caused encephalopathy led to dramatic declines in vaccine uptake and consequent epidemics of disease. Senseless deaths occurred because children were not vaccinated. While whole-cell pertussis vaccine was reactogenic, there remains no proof that it caused permanent neurological damage.

Table 2: Vaccine Truths

1. Vaccines are one of the most important public health achievements
2. Public concern about vaccines is pervasive
3. Fear of vaccines can lead to public harm
4. Vaccines are not 100% safe
5. Parents want what is best for their children
6. The public has little understanding of the vaccine development process
7. Risk perception is critical
8. There are anti-vaccine champions
9. Questions remain
10. The decision not to vaccinate is an active decision to accept the risks of disease

This leads to the fourth truth that vaccines are not 100% safe. However, the safety net in place to detect serious adverse effects from vaccines is extensive, beginning with controlled clinical trials and rigorous licensing procedures and continuing with Event Reporting System and ongoing review by bodies like the Institute of Medicine.

The experience with the rotavirus (Rotashield, Wyeth) vaccine illustrates the effectiveness of this safety net. Within one year of licensure, intussusception associated with the vaccine was detected and vaccine use was suspended. The attributable risk is now estimated to be less than one case per every 10,000 vaccinations, which is actually lower than the natural incidence of intussusception (around one in 2,000 infants); this level of risk was too low to have been detected in prelicensure trials, in which approximately 11,000 children received the vaccine. Ongoing clinical trials of new rotavirus vaccines will enroll tens of thousands of children to ensure that those vaccines do not cause intussusception.

The fifth truth is that parents want what is best for their children. The problem is not that they want harm to come to their children but rather that many have become convinced that responsible parenting means protecting their children from the vaccines rather than the diseases. Physicians must reframe the discussion about vaccines so parents understand the risks of the diseases and the risks of the vaccines in the proper context.

The sixth truth is that parents have little understanding of vaccinology. The effort involved in isolating the causative agent, understanding disease pathogenesis, determining correlates of protection, testing vaccine prototypes in animals, establishing safety, conducting field trials and collecting a database that allows for licensure is under-appreciated. This process takes many years of research as well as millions of dollars of funding.

The seventh truth about vaccines is that risk perception is critical. Without minimizing the importance of preparedness for bioterrorism, it is ironic to point out that, most likely, no one will die of smallpox in the United States this year, but approximately 20,000 people will die of influenza. Yet, parents who are leery of influenza vaccination express interest in smallpox vaccine because of the perception of risk. Parents living in non-endemic areas expressed interest in the Lyme vaccine because the disease was perceived to be serious; at the same time, many parents took their children to chickenpox parties because they perceived acquiring the natural disease to be less risky than the varicella vaccine. In the early 1990's, there were approximately 50

pediatric deaths each year from varicella, seven which were more deaths than from any other disease preventable by a routinely administered childhood vaccine at the time.

The eighth truth is that just as there are vaccine champions, there are vaccine anti-champions. No one can argue that the attention brought to vaccine safety issues by activists has not benefited the public. Much of the expansion of the vaccine safety net can be attributed to this activity. However, much of the information that is easily accessible to parents (e.g. on the Internet) is not accurate. The only available filter through which parents can interpret this information is the primary-care physician. Studies have repeatedly shown that, in addition to laying out the facts, the personal endorsement of the physician is the most important aspect of advocating for vaccines in practice.

Questions remaining

The ninth truth is that many questions about vaccines remain. For example, which vaccine safety claims are worth investigating? Clearly, not every claim can be studied, and perhaps only those with reasonably plausible hypotheses deserve scientific attention. How can the medical community and the vaccine industry address issues of conflict of interest while advocating for vaccination? What financial and logistical barriers do practitioners face in promoting vaccination? How do families differ in their orientation toward traditional medicine, and how should the physician's approach to discussing vaccine safety with parents be adjusted based on that orientation? Parents may think that in accepting vaccinations they are making active choices and that in refusing vaccinations they are passively deferring to the status quo. In fact, the tenth truth is that the decision to refuse vaccination is an active decision to accept the risks of the disease. This idea may help some parents place the true risks and benefits of vaccination in perspective and make informed decisions.

To read the complete article and references, visit the Infectious Diseases in Children website at: http://www.idinchildren.com/monograph/0301/frameset.asp?article=truths.asp.

ACIP Releases Provisional Recommendations for Prevention of Varicella

In June 2005 and June 2006, the ACIP made policy changes for use of live, attenuated varicella-containing vaccines for prevention of varicella. Changes include routine two dose varicella vaccination of children and second dose catch-up varicella vaccination for children, adolescents, and adults who previously had received only one dose. The ACIP also expanded recommendations for varicella-containing vaccines to promote wider use of the vaccine for adolescents, adults, and HIV-infected children and approved new criteria for evidence of immunity to varicella.

Provisional recommendations for prevention of varicella: All children <13 years of age should be administered routinely two doses of varicella-containing vaccine, with the first dose administered at 12-15 months of age and the second dose at 4-6 years of age (i.e., before a child enters kindergarten or first grade). The second dose can be administered at an earlier age provided the interval between the first and second dose is at least three months. However, if the second dose is administered at least 28 days following the first dose, the second dose does not need to be repeated.

A second dose catch-up varicella vaccination is recommended for children, adolescents, and adults who previously had received one dose, to improve individual protection against varicella and for more rapid impact on school outbreaks.

Catch-up vaccination can be implemented during routine healthcare provider visits and through school and college entry requirements. Catch-up second dose can be administered at any interval longer than three months after the first dose.

To read the provisional recommendations for prevention of varicella vaccine, visit **http://www.cdc.gov/nip/vaccine/varicella/varicella_acip_recs_prov_june_2006.pdf**

USIIS USER TIPS

USIIS User Tip 1:

With school starting many of us will be printing the School Report (pink card). The School Report will auto-populate the parent/guardian information automatically, if that information has been completed correctly in the Pat Info screen. In the Pat Info screen there are three places for this information: Mother's Information, Father's Information, and Guardian Information. If the mother's information and the father's information are filled out, the mother's information will appear on the school report. If you want the father's information to appear instead of the mother's, you should place his information in the Guardian section. If just the father's information is filled out, and the mother's information is blank, then the father's information shows up on the school report. The order of precedence is: Guardian, Mother, and then Father. Also, please remember that you can update or change this information yourself. However, you cannot remove completed fields and leave them blank with no information. If you have any problems, or for more information on this tip, **contact J.C. Alexander at 801-538-6827 or jcalexander@utah.gov.**

USIIS User Tip 2:

Do you want to get the immunization rates up in your clinic, but don't know which patients to concentrate your efforts? USIIS can help. The Reminder/Recall report in the Admin Report section of USIIS has been improved. Previously the report displayed patients that were due during the date range you specified. It still performs this function, but will also list all of the patients that were due or overdue before the date range. This will provide you with a larger number of patients to call for an immunization visit, decreasing the number of patients who are missed. If you have any problems, or for more information on this tip, **contact J.C. Alexander at 801-538-6827 or jcalexander@utah.gov.**

USIIS User Tip 3:

The easiest way to search for your patients, if you know the patient ID, is to use the patient ID field and not the patient name. To conduct this type of search, enter the patient ID for the patient you want to find in the "Patient ID" field of the "Pat Search" screen and hit the "Enter" key. Do not tab past the "Patient ID" field. If you do tab past this field, then click a single time in the "Patient ID" field with the cursor blinking after the number. Then hit the "Enter" key. If the patient ID exists in USIIS under your clinic, USIIS will automatically direct you to the "Patient Information" screen with the patient's information displayed. For any clarifications on this tip, **contact J.C. Alexander at 801-538-6827 or jcalexander@utah.gov.**

USIIS User Group Meetings

Cache Valley USIIS User Group
Call 801-538-9450 for information.

USIIS Oversight Committee
October 8, 2006
Utah Department of Health, Salt Lake City
Room 125, 1:00 p.m.

Northern Utah USIIS User Group
October 12, 2006
Ogden Regional Med Center, Ogden
12:00 p.m.

For more information regarding User Group meetings or to establish a User Group in your area, please contact Janel Jorgenson at 801-538-9991.

New Resource for Healthcare Professionals. Print this PDF document at http://www.dhs.ca.gov/ps/dcdc/izgroup/pdf/IMM-508.pdf.

Utah Department of Health
IMMUNIZATION PROGRAM
Immunize for healthy lives

P.O. Box 142001
288 North 1460 West
Salt Lake City, UT 84114-2001

Check out our websites!

www.immunize-utah.org

www.usiis.org

Welcome New VFC Providers!

Dinh Family Medicine

Granite School District

Jordan Ridge Family Medicine

Joseph M. Johnson, MD

Rock Run Medical

U of U Centerville